HOME AND COMMUNITY BASED SERVICES
WAIVER REFERRAL FORM

Client Name _____

SSN_____ Client Waiver ID _____

1. Under which Waiver is the client seeking coverage?
This client meets the level of care criteria for services in (circle one)
a) nursing care facility- NF b) ICF/MR facility.

If the client meets the Medicaid requirements, Home and Community Based services (circle one)
a) will b) did begin on

_____
Signature of Waiver Case Manager Ph.# Date

_____
Referring agency and mailing address

2. Bureau of Eligibility Services (BES) or Work Force Services (DWS) Response.
Medicaid eligibility for this client has been determined, using the eligibility criteria for the Home and Community Based Services Waivers.

☐ This client is eligible for HCB Medicaid coverage effective (Date)_____
A. PACMIS Client ID #
B. Client name as entered in PACMIS
C. The spenddown amount is

☐ This client is eligible for Medicaid effective on _____; but NOT Medicaid coverage for HCB services. This is because

☐ This client is not eligible for Medicaid or Medicaid coverage for HCB services. This is because

Signature of BES/DWS Eligibility Case Manager Ph.# Date

Referring agency and mailing address

3. Check Continued Waiver Eligibility.
This client has:

☐ Entered nursing home (Date/nursing home name) _____

☐ Moved (new address)_____

☐ Died (Date)_____

☐ Other _____

Date Eligibility Case Manager Closed Case
Date Waiver Case Manager Closed Case

Signature of Waiver or Eligibility Case Manager Ph.# Date

_____
Referring agency and mailing address

Copies retained by: Waiver Case Manager and Eligibility Case Manager

INSTRUCTIONS FOR FORM 927

PURPOSE: When we refer to Waiver Case Manager we are referring to employees of DSPD, AAA, or Family Health designated to determine medical Medicaid eligibility. When we refer to Eligibility Case Manager we are referring to employees of BES or DWS designated to determine financial Medicaid eligibility.

To get Medicaid to pay for waiver services, a client must be financially and medically eligible.
This form is designed to notify agencies working with waiver Medicaid that eligibility has been established. The Waiver Case Manager originates the form. When all medical eligibility requirements are met the Waiver Case Manager completes section 1 and sends the form to the Eligibility Case Manager. When all financial eligibility requirements are met the Eligibility Case Manager completes section 2 of the form, makes a copy of the form for the eligibility file and sends a copy of the form back to the Waiver Case Manager. The copy is placed in the waiver file. In the event that continued eligibility is questioned or the case is closed complete section 3. Case Managers are responsible to notify each other of questions or closures. To optimize program integrity, it is vital that there be a cooperative line of communication between case managers.

PREPARATION: The Waiver Case Manager fills in the Name, Social Security Number, and Client Waiver ID of the person receiving waiver services.

Section 1: The Waiver Case Manager fills in the name of the waiver the client is being referred to, circles the appropriate level of care criteria used to determine medical eligibility - "a) nursing care facility NF b) ICF/MR", and circles the appropriate word to reflect the time period coverage will start or started - "a) will b) did". Next, he/she fills in the date home and community based services start, including retroactive Medicaid months in which the client already received Medicaid waiver services, signs, includes his/her phone number, and dates the form. Include the name and mailing address of the referring agency. Send this form to the Eligibility Case Manager.

Section 2: The Eligibility Case Manager determines Medicaid eligibility. If the client is eligible check the first box and write in the eligibility start date. List the PACMIS ID number, the client's name as entered in PACMIS, and the spenddown amount. If the case is denied for waiver services but opened for another type of Medicaid, fill in the information requested in the second box. If the case is denied for both waiver and Medicaid, fill in the information requested in the third box. Sign, date, list your phone number, referring agency, and mailing address. Sent the completed copy back to the Waiver Case Manager.

Section 3: To be used by both the Eligibility and Waiver Case Manager. Use this section when there is a question of continued waiver eligibility or when the client is no longer receiving or is no longer eligible to receive waiver services. Enter the date and reason for the question of continued eligibility or closure in the designated areas. Sign, date, list your phone number, referring agency, and mailing address. Send the form to the appropriate Case Manager.

If the client enters a long term care facility (nursing home, hospital, etc) and is single or married to a person who is a resident of a long term care facility, notify the Eligibility Case Manager if the stay involves any portion of three separate months. If the client is married and the spouse resides in the community, notify the Eligibility Case Manager if the stay is more than 30 consecutive days.

A review of both medical eligibility and Medicaid eligibility must be completed at least once every 12 months. The Waiver Case Manager must verify to the Eligibility Case Manager that medical eligibility is met at each review. Either update the 927 by talking to the Waiver Case Manager (document on CAAL) or get a new 927 completed by the Waiver Case Manager.